Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

KILLEEN INJURY CLINIC INC
5931 DESCO DRIVE
DALLAS TX 75225

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative
Box Number 45

MFDR Tracking Number
M4-10-3152-01

MFDR Date Received
March 9, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The insurance carrier has reduced payment for this claim stating state fee adjustment. On this date of service [injured employee] completed 8 hours of the work hardening program. The insurance carrier processed payment for 7 hours not 8. Additional documentation was submitted with the request for reconsideration however the carrier maintained their denial. Due to this it is no submitted for your review and resolution."

Amount in Dispute: $96.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office has reviewed the dispute packet and documentation submitted by the requestor, Killeen Injury Clinic for date of service 6/2/09. The Office allowed for reimbursement for 7 hours. In review of the documentation it indicates the injured worker spent [sic] hour 3:00-4:00PM utilizing a Wii Sports/Fit game. The Office will maintain its denial for this hour based on no medical evidence to support the Wii programs are beneficial to a Work Hardening program."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 2, 2009	97546-WH-CA	$96.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the Medical Fee Guideline for Workers' Compensation Specific Services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 45 – Contract/legislated Fee Arrangement Exceeded
   - W1 – Workers' Compensation State Fee Schedule Adj
   - ORC – See additional information
   - Note: Allow at 5hrs due to Wii sports is deemed experimental treatment
   - B13 – Payment for service may have been previously paid
   - W4 – No additional payment allowed after review
   - Note: Previously allowed @5 hours. As one hour for Wii sports is deemed experimental treatment

Issues

1. Was the workers' compensation insurance carrier entitled to pay the health care provider at a contracted rate?
2. Did the requestor submit documentation to support the one (1) hour billing of 97546-WH-CA (Wii Sports)?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced disputed services with reason code "45 – Contract/legislated Fee Arrangement Exceeded." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on January 11, 2011 the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required. The Division concludes that pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. Per 28 Texas Administrative Code § 134.204 "(b) Payment Policies Relating to coding, billing, and reporting for workers' compensation specific codes, services, and programs are as follows: (1) Billing. Health care providers (HCPs) shall bill their usual and customary charges using the most current Level I (CPT codes) and Level II Healthcare Common Procedure Coding System (HCPCS) codes. HCPs shall submit medical bills in accordance with the Labor Code and Division rules. (2) Modifiers. Modifying circumstance shall be identified by use of the appropriate modifier following the appropriate Level I (CPT codes) and Level II HCPCS codes. Where HCPCS modifiers apply, carriers shall treat them in accordance with Medicare and Texas Medicaid rules. Additionally, Division-specific modifiers are identified in subsection (n) of this section. When two or more modifiers are applicable to a single HCPCS code, indicate each modifier on the bill. (3) Incentive Payments. A 10 percent incentive payment shall be added to the maximum allowable reimbursement (MAR) for services outlined in subsections (d), (e), (g), (i), (j), and (k) of this section that are performed in designated workers' compensation underserved areas in accordance with §134.2 of this title (relating to Incentive Payments for Workers' Compensation Underserved Areas)."

   Per 28 Texas Administrative Code § 134.204 "(h) The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a Division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or carrier."

   Per 28 Texas Administrative Code § 134.204 "(n) The following Division Modifiers shall be used by HCPs billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes. (1) CA, Commission on Accreditation of Rehabilitation Facilities (CARF) Accredited programs--This modifier shall be used when a HCP bills for a Return To Work Rehabilitation Program that is CARF accredited."

The requestor seeks one hour of CPT code 97546-WH-CA denied by the insurance carrier with denial note "Allow at 5hrs due to Wii sports is deemed experimental treatment." No documentation was submitted by the requestor to support that the additional one hour of reimbursement for the Wii sport is part of a CARF accredited work hardening program.

3. Review of the submitted documentation finds that the requestor has not submitted sufficient documentation to support the one (1) hour billing for Wii Sport. As a result, reimbursement for the requested one hour is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 24, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.